An Anatomy of Collective Actions in Bangladesh
(Very Preliminary Draft)

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Introduction

In Bangladesh a commonly accepted notion of citizenship endowed with certain minimum basic rights does not exist. Although a generalised concept of citizenship has been formally articulated, i.e. in the constitution, and has the appearance of being all-inclusive, this is more in form than in content and reality. The meanings/concepts of citizenship at the level of peoples lived realities are not easily perceived or conveyed, and citizen's rights are at best identified as fragmented claims or privileges dependent upon the good intentions of more powerful persons and agencies. Even when claims and privileges are recognized as legitimate, these are perceived as being tied to social status and relative position and are rarely all-inclusive. For example, the poor do not expect to receive the same service as the non-poor from service providers or to be ensured the same degree of protection by law enforcing agencies. Similarly, women do not expect to have the same say in household decision-making as men or to be paid similar wages as men for the same work. There are strong structural constraints that have prevented the translation of the formal concept of citizenship, with certain embodied rights however narrowly conceived, to one that reflects people's real perspectives and is widely ascribed to. These structures are supported by social norms that have traditionally generated much inequality and have led to a tacit acceptance of considerable social injustice and an absence of a "culture of rights".

However, although a realistic and inclusive concept of citizenship may not be forthcoming there have been numerous instances in which the failures of provision and protection of entitlements, claims and privileges have been recognized and articulated, and of examples of citizen's mobilizations for protecting and/or re-establishing such claims and privileges. These collective actions have been largely with respect to economic and social claims and privileges, and more recently with respect to political claims as well, and have ranged in terms of both the magnitude of their inclusiveness and the importance to people's livelihoods. The 1971 independence movement has clearly demonstrated that, despite structural barriers and a silent tolerance of social inequality, an all-inclusive, equalizing and widely relevant notion of citizenship can be perceived and articulated, and even be acted upon, if the reasons for mobilization are sufficiently strong.

The history of collective action in Bangladesh is quite long, going back two centuries to the peasant uprisings against the zamindars (land lords) and the East India Company government, the most recent of which was the "Tebhaga" movement of 1946. Since then, of course, we have all experienced the independence movement of 1971, a collective action of unprecedented proportions. The underlying causes of the peasant actions were to re-

establish claims and privileges customarily enjoyed by the peasants under traditional norms (of obligations of zamindars and landowners) and laws of the land, and to protest extreme forms of economic exploitation by government agents and revenue/tax collectors. In the case of the peasant uprisings the commonly held notions of claims, privileges and obligations were in all cases relative to the social position of the individual or the group. The peasant actions and, to a lesser extent, even the movement for independent Bangladesh, were driven more by a sense of social justice and fair play, than by a demand for "rights" as embodied in the modern notions of citizenship. A common concept of "citizenship" with certain generalized and absolute rights and obligations did not actually begin to emerge until after the independence movement. Since all of these actions have been violent to some degree they perhaps represent an extreme form of collective action.

In more recent times, collective actions have been more varied in form and also less confrontational and, as a result, less recognized as collective actions. However, the notion of absolute rights and obligations and the related "language" of rights (food, clothing, shelter, education and health) have now become more common than before, possibly linked to the post independence evolution of democratic processes in civil and political life, however weak and immature they may be. Social injustice is less in the forefront of contemporary collective actions since the commitment to rights at the formal level is plentiful. However, the gap between the formal obligations of the state in the provision of rights and the reality of people's lives in terms of actual rights enjoyed still exists. This evidence of the lack of responsibility of the powerful in society about their obligations to fellow citizen's constitute the basis for many of the collective actions of today.

Citizenship and collective action

The structural constraints to the emergence of meaningful concepts of citizenship and the articulation of relationships between the state and its citizens can be traced to what Kabeer (2000) calls the problems of 'recognition' and of 'resources'. In other words, the problem is one lack of 'recognition' by state, market and community agencies of the rights and entitlements of citizens and their own obligations and responsibilities to them, and the problem of lack of 'resources' on the part of citizens to articulate, voice and demand those rights and entitlements. This results in the exclusion (non-participation) of the large majority of the population from the social, economic and political processes that affect their lives and livelihoods. Although poverty has been a major contributing factor for both 'recognition' and 'resource' constraints, it is not the only cause of exclusion in Bangladesh society. State policy and state agencies implementing those policies (like law enforcing and legal agencies, local government agencies, service providing agencies, financial institutions) reinforce existing political, social and market structures of exclusion so that claims and privileges allowed under norms and customary laws and even formal rights guaranteed by the state are not adhered to equally for all. As a result rights are not articulated similarly for all people at all times and, even when articulated similarly (as in the constitution), rights are not provided and/or safeguarded in a socially just and equitable manner.

In addition, the near absence of accountability of state and other (private, non-governmental organisation, donor) actors/institutions also leads to exclusion, since those in 'power' remain beyond the reach of those without power or 'voice'. The accountability of state and non-state institutions to its "citizens" is further eroded by global and donor pressure to increase dependence upon markets, which fail to function effectively due to non-performing institutions. Thus, state and social/economic institutions, singly and in collusion, are formidable barriers to the articulation and the equal provision of rights to all. Besides, these institutions play an important role in establishing the language of rights and in the articulation of rights at the level of individual people's lives. Hence, existing institutions present strong impediments to the articulation of an inclusive and relevant concept of citizenship.

Given people's exclusion from the processes of decision-making affecting their social, economic and political rights, and the absence of accountability of those in power who make decisions, collective actions provide the space and the opportunity for people to "become citizens" and engage in processes that "make rights real" for all. Thus, an exploration of people's perceptions about their rights as citizens and their understanding of the meanings of citizenship in the context of their lived realities may be possible by examining and analyzing collective actions that have mobilized people around the attainment of economic and social rights. This paper examines a number of ongoing collective actions in Bangladesh in order to identify a preliminary framework for analyzing the process of contemporary collective actions with the objective of addressing the following basic research questions:

1. Does this process of collective action lead to a more relevant understanding and articulation of rights and claims and a more meaningful concept of citizenship?
2. To what extent do interests of the different partners in the collective action indicate the emergence of an inclusive concept of citizenship?
3. Does the process of collective actions allow people to overcome the "resource" and "recognition" constraints that lead to the non-provision or the violation of their rights and claims?
4. How equitable are the costs generated and benefits derived from these actions?

Methodology and analytical framework

In this paper 'Collective action' is defined as conscious/purposeful activities that mobilize people around shared problems of the failure of state and other formal and informal institutions in providing, ensuring and safeguarding people's formal rights and informal claims awarded under customary norms and laws of the land. Collective action provides the social and the political space, as well as the operational/functional mechanism, for rights and claims to be realistically articulated and identified (to gain or acquire voice), to gain visibility (to be heard) and to be effective (to be able to influence the action of others).

The sample of collective actions in this study was selected to represent cases of mobilization around rights and entitlements with respect to health and education. The reason for choosing these two sectors was that inequalities in health and education have been just as persistent and as wide as inequalities in income, if not more, and probably contribute to social exclusion to a greater extent than poverty. The cases were selected to cover state, private and

non-governmental actors, and included actions of varying durations, including some that were relatively new. There were also partnerships between state and private actors, between state and non-governmental organizations (NGO) and between NGO and women's groups. In total there were two collective actions regarding rights in the health sector, one collective action regarding education rights and one collective action regarding reproductive rights.

In order to generate answers to the research questions posed above the following analytical framework will be used to examine each case study:

1. Identity of the group or partners in the collective action

The background of the collective action provides an understanding of the reasons for the mobilisation and of the identity of the group, i.e., the observed partnerships in the collective action. One important aspect of the background is an historical account of past and immediate events leading to the collective action (what prompted the action, who first recognised the problem as needing collective action, who mobilized other actors, who joined first, who joined later, and so on). This will help to identify the group engaged in the collective action and their individual and collective interests in the action. Another important aspect is the location of the collective action in terms of whether it was spontaneous from within the community or induced from outside. The mobilisation process, the operational mechanism of the group and the sustainability of effects will all depend upon the identity and the location of the collective action.

2. Reasons for mobilisation

The reasons for mobilisation become clearer with the identification of the group or the major actors, and their separate perspectives and individual interests in joining the collective action. The basis for the collective action is to generate a social and political space in which the different partners can mobilise around a set of common interests and/or shared problems. The reasons for the mobilisation can vary according to the needs of the partners for collective action. Very broadly, these reasons are as follows: the identification and articulation of rights in a manner relevant to people's lives; establishing the visibility of the group and increasing awareness about those rights at the appropriate levels and within the appropriate institutions and organizations; and undertaking group activities that are effective in influencing the action of others (state, private sector, NGO sector, professional bodies, service providers) responsible for the provision of rights. Each collective action may be mobilized around any or all of these reasons and different actors or partners may come together from different perspectives and for different reasons around a common issue.

Articulate rights/entitlements: A major reason for mobilization is the articulation of rights or claims in a relevant and realistic manner, i.e. in a way that reflects the lived realities of people's lives. The articulation of rights is influenced by how these are perceived and understood by the different partners in the collective action. A first step in this articulation is the identification of commonalities of interests in terms of violation or non-provision of the rights of certain persons or population groups. The existence of a well-identified and

strongly articulated shared interest is a prerequisite for a successful collective action, i.e. one that is able to achieve its functions efficiently and equitably.

Establish visibility: Another important reason for mobilization is to establish the visibility of the group and raise awareness about the common articulation of rights or, in other words, to generate "voice" at the appropriate levels and within the relevant agencies of the state, community and market. This consists of highlighting and revealing the failure of relevant agencies to provide, ensure or safeguard rights.

Influence action: A third reason for collective action is to generate sufficient pressure upon relevant agencies, whether state, community or market, to lead to actions that redress the failure of provision of rights, or to generate a voice that is loud and strong enough be "heard". Thus, influencing the action of others forms an important, and usually the major, reason for mobilization. The articulation of rights and entitlements and the establishment of visibility are often pre-conditions for attaining the ability to influence the action of others.

3. Functions

The functions of a collective action may be distinguished into either claims functions or efficiency functions. Claims functions have the objective of establishing rights and claims of the group in the collective actions of failures to perceive and articulate, and to provide and protect rights and claims of the group. Claims functions aim at transforming existing structures, institutions and norms so that these no longer pose a barrier to the perception and the provision of rights. In that respect claims functions, if these can be established, have more long-term gains but may entail considerable short-term costs for the different partners in the group. For example, a collective action may have the objective of gaining access to khas or government land by a group, say the landless in any locality; or of establishing the right to be represented in shalish or local court, by women. Thus, collective actions having claims functions often confront existing structures for establishing formal rights or traditional customary claims.

Efficiency functions have the objective of increasing the efficiency of operation of the group within existing state, community and market structures. Thus, a collective action having efficiency functions will attempt to establish rights in collective actions of failures of access to rights and claims when these have been articulated and recognised but not provided or protected. Efficiency functions are for making people and individuals more efficient operators or to function more effectively within existing agencies of the state, community and the market. For example, collective actions having efficiency functions may have the objective of increasing poor people's or women's access to markets through micro-credit, greater information and skills upgrading; increase integration and bargaining power of powerless producers by increasing links to producer groups, peer networks and support groups. These collective actions are accommodated within existing structures and, therefore, have greater immediate or short run gains rather than long-term ones, and will be relatively less costly for different partners.

4.Operation

The analysis of a collective action requires an understanding about the mode of operation of the group of partners in collective action. The mode of operation is characterised by the following aspects of group functioning: rules of inclusion into and exclusion from the collective action; the internal relationships between the partners, especially between the leaders and other members of the collective action; the role of the leadership; mechanisms for monitoring individual action and conflict resolution; and processes for ensuring accountability of decision making.

The efficiency of group operation can be assessed by the degree to which consistency of action of all partners is maintained. Generally, this means that all partners have to agree to abide by some common rules of operation, even if they mean foregoing some individual interests to achieve the greater interest of the entire group. In some cases collective actions can themselves erode the claims and rights of others outside the group when there is confrontation with existing structures of power. Maintaining consistent action of all partners can be achieved through different means depending upon the strictness of rules of inclusion, the hierarchy of internal relationships, the strength of leadership roles, the effectiveness of monitoring action and resolving conflicts, and the degree to which decisions are accountable.

5. Equity aspects

Finally, the effects of the collective action are measured by the costs and benefits experienced by the partners. Since different partners engage in the collective action from different stances and with different interests around a common rights issue costs and benefits experienced are bound to be also different. Costs include interests or privileges that have to be foregone to maintain group discipline and internal consistency, as well as the costs of resistance and confrontation with existing structures that constrain the enjoyment of rights. Benefits include the sense of empowerment that comes with the recognition of rights, the visibility of the struggle for rights, and the actual realisation or establishment of rights and claims struggled for. More indirect benefits include the generation of social capital through the collective action and the wider impact of overcoming resource and recognition constraintsin the provision of rights.

Case Study 1: Textbook scare case

1. Group identity

In Bangladesh the provision of education services has been the primary responsibility of the state, although both state and private schools provide these services within the mainstream education system. As part of this obligation school textbooks are made accessible by the state to all students enrolled in the mainstream schooling system. This is done by subsidizing the cost of school textbooks by distributing books to primary students (grades 1-5) free of cost through state and private schools and by selling books through designated dealers operating in the market at low cost to students in grades 6-9. In 2001 there was a large delay in the production and distribution of school textbooks to the extent that students were without books well into the school year (until March). It was widely believed that the reason for the this unusual delay was because the general practice[1] about awarding contracts for printing, binding and distribution of this huge number of books (80 million) was violated in 2001. The entire job was awarded to one firm at considerable risk, even when the risk had been apprehended in advance. As a result, textbooks appeared late on the market and were available late for free distribution by more than two months and were also of very poor quality (cover, paper, security mark). Additionally, since the monopoly on production and distribution was enjoyed by the same organization, students were compelled to purchase notebooks produced by that firm when buying the textbooks recommended by the National Curriculum and Textbook Board (NCTB).

The delay in production was first discovered by newspapers, which reported on the inefficiency of the contractors to complete production of the huge quantity of books (80 million) in time for distribution when the school year began in January. This was picked up by several student organizations that issued press statements, but only the student wing of one of the left political parties went on to further activities. The activities were to organize public protest rallies in visible locations (Press Club, Shahid Minar, Ministry of Education, office of the NCTB), mobilize the school student community and present a memorandum to the Prime Minister demanding greater accountability within the relevant state agencies. School students from some schools in Dhaka joined some of these activities later on.

The interest of the student organization was to expose the lack of accountability and subsequent inefficiency of state agencies, which they described as systemic and long-

[1] The usual practice has been to award the job of printing, binding and distribution of textbooks to three different Associations of printers, binders and distribution, comprising numerous smaller member firms. In 2001 these three Associations refused to take the job at the minimum cost fixed by the Ministry of Education, and the entire contract was awarded to a single firm with no previous experience. This was done despite the observations of the inspection team of the Curriculum Board that this firm did not have sufficient capacity to print or bind this huge quantity of books and distribute them throughout the country. The Chairman of the Board wrote to the Ministry seeking its advice on the matter, but there was no response. Being pressed for time and due to the unresponsiveness of the Ministry to settle the differences with the three Associations through dialogue, which they were apparently quite prepared to do, the Board awarded the entire contract to the one firm with the minimum tendered bid.

standing rather than random and new[2]. The interest of the school students was mixed. They were motivated to join the protests because, although books were generally late every year, they were unusually late this year; they also joined because this was a novel and exciting experience for them and they would not be missed from school because of sports and other non-academic events that take place in school during the first two months of the school year. Thus, the interests of the student organization and the school students, although arising from different perspectives, had a common basis for collective action. In that sense the collective action was spontaneous and locally grounded.

2. Reasons for mobilization

The reasons for mobilization were several. First, there was a need for clear articulation of people's right to hold state agencies that provide services accountable for their actions or inactions. Second, there was need to make visible the lack of accountability and inefficiency of state agencies that lead to a violation of school students entitlement to subsidized textbooks of good quality and in a timely fashion. In this case the need for mobilization was to raise awareness at different levels (state agencies, school authorities, guardians, school students and the general public, even the Prime Minister) about the violation of contracts between the state and its citizens by state agencies themselves, and the inability of state agencies to ensure that private profit making firms behave responsibly and operate fairly in the market. Third, there was the need to influence action at the highest policy level to create disincentives for contract violations by private firms and create mechanisms for ensuring accountability of state agencies. This was attempted by demanding the identification and punishment of irresponsible and inefficient persons within state agencies and irresponsible and powerful private firms operating in the market.

3. Functions

The first function of the collective action was to establish the claim of citizens generally and of school students and their guardians particularly, and also of school management and teachers, to have accountable state agencies and responsible market agencies. This is fairly long-term objective since it entails major attitudinal change in the organizational mindset of bureaucratic state agencies. In most cases mechanisms for ensuring accountability of state agencies are already in place but are non-functional because of the bureaucratic red-tapism and the attitude of "passing the buck" (e.g., the unresponsiveness of the Education Ministry to the queries of the NCTB regarding the contract award, saying it was not within their administrative mandate to comment). Ensuring responsible market agencies is also a long-term objective since it requires balanced state control in the form of regulatory frameworks, which are not easily constructed. However, a significant degree of market responsibility can be assured and even nurtured by having in place accountable and functional state agencies.

The second function was to assist school students, and indirectly school management and teachers, to function more efficiently by increasing their bargaining power in establishing

[2] This year it only happened to be worse than average because of the blatant … by the contractors and extreme inefficiency and negligence by the state agencies.

their claims. With respect to the bureaucracy and the market school student's are in a relatively vulnerable position. Their claims with respect to access to subsidized good quality textbooks in a timely manner are accorded greater weight because of the support of the collective group, increasing their relative bargaining strength. This function is partly contingent upon having accountable and pro-active state agencies. In their absence, collective actions of this type may be important in the short run for adding clout to student's claims, but may be difficult to sustain over time.

4. Operation

The identity of the actors in the group suggests that inclusion into and exclusion from the collective action, while implicit, followed strict rules. School students were readily included since they would add considerable visibility and credibility to the objectives of the collective action. They were easily accessible through the network of branches of the student organization in various schools in the capital. School students were also relatively easy to organize since they were willing to submit to discipline and used to following rules without questions.

Rules of exclusion were also rigid. First, other student organizations attached to different political parties although interested were not included[3]. It seems likely that exclusion arose from internal group dynamics rather than from external factors like non-response from other political parties, since no attempts were made to mobilize other interested student organizations, nor to involve other more mainstream political parties, especially the major opposition party. Ideological differences and the fact that the political represented by the student organization was a relatively minor one and did not want to be overshadowed by a larger party may have both played a part in exclusion.

Second, although students were readily included, guardians and school management despite being interested parties were conspicuously absent. Their absence was partly due to external factors. State run schools cannot in principle be party to public protests against state agencies[4]. This was also true in part for private schools receiving government subventions, which most mainstream private secondary schools do. Many private schools, and some state schools, also do not allow student politics on campus, in which case the student organization had no links with their students and were unable to co-opt them into the protests. The mobilization of guardians is even more problematic because they are not easily accessible through networks like students are.

However, the exclusion of guardians and school authorities was also partly a conscious decision[5]. The reason for their exclusion was related to internal group functioning and the

[3] Although several student organizations initially responded to newspaper reports, only one student organization mobilized the collective action and persisted throughout.

[4] This was stated by the student organization and roughly corroborated by one head teacher from a school that had several students participating in the protests.

[5] This is suggested because the students interviewed reported that neither their schools nor their guardians were aware of their participation in the protests. Parents were told that they were at school since they went in their school uniforms, were picked up from the school gates, and returned home at the usual time. School authorities did not miss the students since they had been contacted personally by the student organization outside the

maintenance of smooth internal group relationships. While generally agreeing with the reasons for mobilization and the justification of the collective action, guardians were not very supportive of the methods employed, namely the participation of their wards in the public protests[6]. School authorities and teachers were likewise not very supportive of the idea of using school students to gain greater visibility and media coverage. Hence, group operations would have been constrained with the inclusion of guardians and school management.

Internal group relationship between school students and the student organization was extremely hierarchal but mutually reliable, with the student organization representatives leading the collective action. The role of the school students was to participate in the protests according to instructions received. School students followed instruction precisely, even to the extent of deceiving parents and school authorities[7]. The role of the student organization was to mobilize the school students and ensure their safety during the protests. Although there were no formal mechanisms to monitor the accountability of the leaders, i.e., the student organization, to the school students, such as a teachers and guardians oversight committee, the leaders performed their role remarkably well.

School students accepted all decisions communicated by the student organization without question. They did not express any need for participation in the decision-making process, nor were there any reported mechanisms for feedback from the school students. Decisions were, thus, not participatory and only those directly concerning the school students were communicated to them.

Maintaining consistency of action of the group was relatively simple because the student organization was admired by and inspired a lot of confidence in the school students who were willing to follow instructions precisely; in turn since the school students were an essential part of the public image of the protests and lent it credibility, the student organization was also compelled to safeguard the interest and the wellbeing of the school students during the protests. The incentive of a day spent away from school in an exciting adventure covered by the media helped a great deal to maintain consistency of behaviour. Because of the strict exclusion criteria there were almost no conflicts of interest and the operation of group activity was quite flawless.

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school premises and because regular classes had not yet begun due to various non-academic events like annual sports, picnics, the ongoing SSC exams, and so on. Interviews with school authorities and several guardians confirmed this.

[6] Parents expressed apprehension about the safety of their children and the possibility of costly disciplinary action by school authorities against participating students.

[7] Participating students reported that they were informed over telephone or in person about the dates of protests, when and where they would be picked up, and that they were to be in their school uniforms. They never questioned these arrangements, and appeared to have full confidence on the leaders of the student organization regarding their own safety and wellbeing.

5. Equity aspects

The costs of the collective action were fairly small, especially for the student organization. Some notional costs were borne by the school students in the sense of deceiving parents and school authorities, but these do not appear to be real costs. The safety costs were more real, however, and could have been substantial in the event of violence or brushes with law enforcing agencies, but nothing conclusive can be said in the absence of information. In any case, even though costs were minimal, these were not equitably distributed and were borne by the school students.

With respect to benefits, not much was evident during the period of observation. As noted earlier all the objectives were long-term and implied a considerable lag before benefits, if any, would become visible and be perceived. The immediate benefit of media coverage, if this is indeed a benefit, was enjoyed by the student organization more than by the school students. For them, however, the immediate benefit was an exciting day, a picnic lunch, a bus ride through the city, etc. In the long-term, however, if the objectives of the collective action are achieved the school students will reap the benefits of improved access to textbooks; and the student organization and its parent political party will benefit from increased popularity among voters generated from a successful political campaign. Hence, the long-term benefits are likely to be distributed fairly equitably among the participants of the collective action.

In addition to group interests, the interests of others outside the group will also be served. Schools and guardians will benefit from better performance of students and wards; and the public or general citizens will benefit from more accountable state agencies and more responsible market agencies, although the former may be more difficult to achieve. There will be erosion of interests for private rent seeking firms and monopolistic tendencies in the market may be undermined[8]. There will also be erosion of interest for negligent and irresponsible persons within state agencies. On the basis of this, the prospects for the sustainability of the collective action appears to be quite good if this student organization can invest time and effort in the collective action in future with the single-minded persistence it has displayed so far.

Case Study 2: The Family Planning Movement

1. Group identity

This case study is called the family planning movement because it describes the long struggle to legitimize the need for birth control by women within a socio-economic context that favours women's early childbearing and has a preference for sons, and to convince the state to take responsibility for the provision of modern contraceptive services. The struggle

[8] In early March NCTB announced that it was planning to take action against the firm awarded the contract on six counts of violation of the terms of the contract. These included failing to meet the last deadline for delivery of the textbooks, failure to submit a sample of books to the Board, marketing textbooks without proper authorization, using a lower quality of paper than agreed, producing books with lower quality of binding and cover, and selling books at a higher price than agreed.

was initiated nearly 50 years ago by a woman doctor, a gynaecologist by profession, working in the largest government teaching hospital located in Dhaka. Her primary concern was to raise public awareness about the adverse health effects on women and children of frequent and prolonged childbearing, to create social acceptance of birth control as a legitimate health need of all women, especially of poor women[9], and to make contraceptive services available to women who were willing to control their fertility. At this time the International Planned Parenthood Federation (IPPF)[10] was also approaching voluntary organizations in developing countries to establish national family planning associations that would advise and assist governments to address the urgent issue of population control at the national level.

With financial assistance from the IPPF the Family Planning Association of Bangladesh (FPAB) (at that time the Family Planning Association of Pakistan) was established in 1953 as a private non-profit organization. The primary objective was broadened to include the objective of influencing the government to take up population control programmes. Hence, the divergent interests of women's health needs on the one hand and population control to curb the current high population growth rates on the other found a common meeting ground in the form of a family planning association whose message was "A small family is a happy family" and broad interests were the establishment of social acceptance of birth control and the provision of accessible contraceptive services to women. The membership in the FPAB, which was entirely voluntary, was given high visibility by mobilizing the elite (highly placed government officials, professionals and academics, respected social workers, and health professionals) to form the National Executive Committee[11]. Besides these high profile members, volunteers at the local level constitute the bulk of the membership of the FPAB[12]. These women and men have the role of raising public awareness at all levels within their respective communities about women's need for contraceptive services, creating social acceptability of the concept of family planning, and motivating willing couples to adopt birth control methods[13]. The reliance of the FPAB upon local volunteer members

[9] She was motivated from observing first hand the suffering of her patients and their under nourished children from early childbearing and frequent pregnancies that women in Bangladesh society had to endure because of social pressure. She was convinced that birth control through the use of modern contraceptives would alleviate much of the suffering of women, especially for women and children in poor households where a large family was in reality an economic burden rather than a blessing.

[10] The IPPF had been launched the year before at an international conference on the population explosion held in Bombay with the objectives of convincing developing countries of the need to address the problem of population control at the national level, and of establishing a voluntary family planning association in each developing country that would assist in raising awareness about the national threat of the population explosion at policy levels and in convincing governments to tackle this problem.

[11] The Executive Committee consists of 21 members.

[12] At the time of the interview (March 2001) there were 6000 general members.

[13] Initially male and female volunteers are recruited according to the following criteria: 18 years of age or older, must have the recommendation of the local Union Parishad Chairman and recommendations of two senior members of FPAB, must agree to the goals and objectives of the Association, and must have the volunteer attitude and commitment to serve. Membership requires the payment of a fee, which can be either annual or lifetime. Women volunteers have to pay half the fee rates for men members. This is because women are less likely to have access to cash and have to depend upon husbands or male relatives to pay fees and in order to encourage women to join as members. The policy of FPAB is in accordance with the government policy of

increases tremendously the outreach and local relevance of a collective action that is very much elitist and socially removed from the lives of the people it wishes to benefit the most. The fact that membership is voluntary and even entails a membership fee suggests that local level members do have a strong interest in joining the Association. However, their interest can only be surmised: the wish to serve their community, the lack of viable alternatives, opportunity to be someone important in the community, the chance of a job with the FPAB offices.

By 1958 the Association was successful in convincing the government to initiate a national family planning programme, although it continued to function on its own[14]. After the government had incorporated contraceptive services into its mainstream health service in 1965 the FPAB sought to redefine its role from that of pioneer and sole service provider to one of supplementing and complementing the government programme. However, because of the availability of donor funds, it was possible for the Association to continue playing a pioneering role in experiments with service provision and in clinical trials of new birth control methods[15] in pursuance of their primary aim of establishing women's access to safe and reliable contraceptive services.

After the ICPD in 1994 the interests of the association have been further broadened to include the establishment of women's reproductive rights within the system of health service provision and the need to place population programmes within a development context.

2. Reason for mobilization

The reasons for mobilization were several. The first reason for mobilization was to articulate women's claims to good health for themselves and for their children, and their related need for birth control through contraceptive services. This was a primary reason since Bangladesh society puts a high premium on early childbirth and has a fairly strong son preference so that the health costs of women and children do not feature prominently in fertility decision making. Moreover, although not very strongly pro-natalist, there was widespread suspicion about the use of modern contraceptive methods for birth control largely supported and encouraged by religious leaders. It may be noted that in the early stages of this collective action the need of women for birth control was couched in terms of health needs rather than

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affirmative action, and the Association has a target of 50 per cent of women members by 2003. Members do not receive any formal training but do get a session of orientation when they first become members.

[14] In 1958 at the conclusion of a successful meeting and exhibition on the population explosion organized by the FPAB the then military president of the country announced the adoption of the country's first family planning programme, which took a more formal shape in 1965 with the integration of family planning services with the national health programme.

[15] In 1960 the FPAB began experimental activities for launching a nationwide family planning programme; it ran over 31 model family planning clinics attached to government hospitals at the district and sub-district levels; the oral pill was introduced and promoted. In 1969 surgical contraceptive methods were provided in remote areas from its well-equipped mobile motor launch. In 1974 the FPAB started clinical trials on menstrual regulation and injectable contraceptives. In the late 1980s the Association began clinical trials of Norplant through two clinics and implemented a pre-introductory phase trial in 11 clinics. It also introduced the low dose pill experimentally in two clinics.

reproductive rights, and the language of women's reproductive rights only began to appear after ICPD. The second reason was to increase the visibility of this claim and raise awareness about it at all levels, including the general public, the immediate and extended families of women, state agencies responsible for planning and service provision, and policy makers. This reason arose because of resistance from religious leaders[16] and because of the passivity of state agencies, service providers, and families to act in women's interests even when women's risks associated with childbearing was acknowledged. The third reason was to influence government policy with regard to the provision of contraceptive services. This reason emerged because the provision of family planning services at the national level could only be realistically achieved as a result of commitment at the highest level of government and through state machinery. In fact, it was recognized that the provision of contraceptive services within mainstream health services would not be possible outside of state jurisdiction.

3. Functions

The objective of this collective action was to establish the claims of women, and especially poor women, to good health through accessible contraceptive services and a say in fertility decision-making. After the ICPD women's decision-making power was seen as a rights issue and their claims to good health was broadened to include reproductive health, which meant safe pregnancy and childbearing, safe abortion, healthy offspring, access to safe birth control, protection from sexually transmitted diseases, treatment for infertility, and so on.

Another objective was to establish the claim of society at large and future generations to protection from the threat of unrestricted population growth and its probable adverse effects on the economy, environment, and livelihoods.

4. Operation

Although membership in this collective action was voluntary and appeared to be quite unrestricted, several inclusion criteria in recruiting members were evident. First, since membership was voluntary there were unobserved exclusion criteria that self-selected people out of membership, for example the membership fee may have resulted in certain socio-economic categories being over-represented and others excluded. Among those included membership was of two different categories: general members and elite members. The most strict inclusion rule to be applied was the volunteer attitude and commitment to social service, which was generally applicable, although is likely to be relaxed in the case of elite members if their involvement is deemed crucial for adding clout, legitimacy and visibility to the action. It is, however, not clear to what extent this rule was strictly followed since there were no objective criteria for determining this characteristic. The membership fee and the recommendations of the local body leader and senior members of FPAB were screening devices but these could also indicate the existence of other incentives for membership than was apparent. Social status and clout at the highest policy-making level restricted inclusion into the elite membership.

[16] Religious leaders propagated that the use of modern birth control methods was sinful.

Internal relationships were quite hierarchal as indicated by the three-tiered structure of membership of the FPAB[17]. The entry point was as general member at the local level. Upward mobility into higher tiers was by election, so a democratic representative process of decision-making was in place at least in theory. However, a lack of information about these elections makes it difficult to say whether the actual processes were democratic or not. Policy decision-making was the mandate of the senior members and the National Executive Committee (NEC). Policy decision-making was not directly participatory in terms of participation by general members and other intermediate membership bodies except through the electoral process. Hence, the process of policy decision-making was participatory only to the extent that the representation of general members in the higher bodies was truly democratic. It is to be noted that policy decisions have to also accommodate donor preferences and government decisions and directives in the health sector. Programme decision-making, however, were quite participatory through the mechanism of the Annual Project Review Workshop, participated by employed staff and officers of all branch offices of the FPAB, and the local general members[18]. Grass roots feedback to programmes took place both through local staff of the FPAB branch office or through local general members.

The role of leadership, as represented by the NEC, was crucial for efficient functioning and operation of the collective action, given the large and diverse constituency of general membership. The NEC presented a strong and powerful leadership, which was essential to deal with donor and government pressures, and to tackle social resistance to new ideas and concepts. At the branch level the branch executive committees provided the leadership, and were directly accountable to the NEC. Accountability of the highest leadership was ensured through the reports of the NEC to the National Council (NC) comprising of 83 National Counselors selected to represent the entire general members[19]. The NC in turn was accountable to the general members through the Annual General Meeting of all members. Hence, there was quite an elaborate system of monitoring and accountability in place.

The mechanism to monitor the performance of employed staff and progress of implemented projects was done through the Evaluation, Monitoring and Research Cell of the Association[20].

However, the mechanisms in place to maintain consistency of action, especially in leadership positions, were apparently not very robust, as in the case of major conflict of interest. This became evident from the fact that the current president of FPAB had serious differences of opinion with members of the NEC and the staff of the head office, which could not be resolved through any of the above channels of monitoring and reporting. The

[17] These tiers were: general members (6000), Branch Executive Committees (20) and Special Work Unit Executive Committees (11), and the National Executive Committee (1).

[18] This workshop is held annually where project reviews from each branch office are presented and discussed by FPAB employed staff and members from the national to the local levels.

[19] These National Counselors are elected by an electorate comprising of the presidents of the branch offices and one per cent of the general members.

[20] The Research Cell has professionally qualified staff to undertake project monitoring and staff evaluations through structured questionnaires. These evaluations are conducted every two years and used as operations research tools for programmes.

conflict of interest culminated in December 2000 in the president of the Association filing a case against the NEC and all of the National Counselors with the High Court[21].

5. Equity aspects

As with all types of collective actions there were both costs and benefits of participation. The costs were not large since participants' direct interests did not come into conflict with social and economic structures, and consisted mostly of time and effort. These costs were largely borne by the voluntary members, both in Dhaka and in the rural areas and district towns. In the beginning there were also some costs related to the resistance by religious leaders and conservative social elites who directly opposed the idea of modern birth control and indirectly opposed the idea of women's empowerment through an increased say in fertility decision-making. These costs may have been large in the initial stages of the collective action, but must have gradually disappeared with increased acceptance of the concept of family planning, especially at the highest level of government. These costs were unlikely to have been inequitable given that membership was voluntary and anyone who felt that the cost of participation was unfairly large for them could easily leave the collective action.

The corresponding benefits of participation were also not unduly large, probably because participants did not expect to make significant gains from the collective action. Benefits were mostly in terms of self-satisfaction generated from voluntary work and some social recognition that may have resulted in increased social status and prestige. However, it appears that the perceived benefits of executive power may have been relatively greater and even selective because there was considerable conflict of interest within the highest executive body, resulting in a situation that was difficult to resolve internally.

[21] Although the High Court ruling was in favour of the FPAB, the president immediately appealed at the Supreme Court, and the case is pending.

Case Study 3: Health watch committees

1. Group identification

Health care provision in Bangladesh is plagued by negligence of duty and absenteeism of health care providers, poor hygiene and sanitation of physical facilities, lack of respect for privacy and unprofessional behaviour of health care professionals and staff, illegal user fees, inadequate availability of supplies, medicines and equipment, and so on. The Bangladesh government has for sometime realized that state provisioning of health care does not meet the minimum standards of service quality and performance accountability. Although internal mechanisms to ensure quality of care and accountability of service providers have traditionally been in place within state agencies engaged in health care provision these have been non-functional for various reasons. Given this context the Health and Population Sector Programme (HPSP), currently under implementation by the Ministry of Health and Family Welfare (MOHFW) of the government, seeks to deliver good quality health care that is accountable to the service users (accountability to those outside the system) and also ensure the accountability of public agencies engaged in health care provision to the state (accountability within the system) through the direct participation of citizens and service users in a stakeholder watch group[22].

The MOHFW believes that ensuring the accountability of public agencies and employees with the responsibility to deliver health care will not be possible internally (i.e., horizontal accountability), and that monitoring from outside will act as a powerful tool for delivering accountable health service and should even bolster the process of internal performance accountability. Hence, the Ministry has turned to NGOs to help set up citizen's health watch committees composed of local residents to monitor the performance of government service providers at the local level on an experimental basis in nine thanas[23]. The NGO selected by the Ministry has been working in the area to organize poor women and men, mainly the landless and marginal farmers and labourers, around livelihood issues, service provision and accessibility issues, and issues of claims and rights of the poor to government facilities and common properties.

The main actors in this collective action are the MOHFW, the NGO selected to organize the watch committee and the local community served by the specific health facility. The interest of the MOHFW in this CA was to ensure the delivery of accountable and good quality health care to the people, especially the poor, through public health facilities at the local levels. This objective complemented well the interest of the NGO, which was to organize the poor to establish their legitimate claims, in this case, their claims to good quality and

[22] The HPSP was to be implemented through a strategy that would be directly participated by all stakeholders (health service users at the grassroots level, health care professionals and care providers, government, private and volunteer organizations engaged in health care planning and provision, and donor agencies providing financial assistance) in order to ensure the smooth delivery of health care in an accountable and transparent manner.

[23] In October 1999 the MOHFW organized a day-long workshops in nine thanas with the objective of establishing stakeholder health watch groups at the local level. Earlier, a national Stakeholder Committee had already been formed, which had taken a decision to set up grassroots stakeholder watch committees composed of local people and professional groups at the thana and union levels.

responsible health care. Another related interest of the NGO was to support the poor in accessing existing public health services. The interest of the local community was to have a responsible and answerable public health service in the locality that maintained a minimum standard of quality and was accessible to all users, poor and non-poor.

2. Reason for mobilization

The reasons for the formation of this partnership between government, NGO and local people were several. The first reason was to articulate the rights and claims of local people, especially the poor who constitute the major users, to good quality public health care. A related reason was the articulation of user's demand for an accountable public health service that would be answerable to the local users. The second reason was to make the health watch stakeholder group and the above claims more visible generally and, in particular, more relevant to the performance of health care providers in government facilities. The third reason was to influence the action or performance of health care professionals and other service providers so that health care provision meets minimum standards, is more responsible and responsive to user's needs and demands, and is answerable to users and not just to higher state authorities. Influencing the poor to be more active in accessing services and all users to be more active in demanding good quality and accountable health service was also a major related reason.

3. Functions

The objective of the CA included both claims and efficiency functions. The claims function was the establishment of the rights of local people, especially the poor residents of the area, to good quality and accountable public health services. This function involved the transformation of state health provisioning with respect to actual service delivery and with respect to the accountability of performance of health care and other service providers. The strategy to achieve this was identified as the direct participation of users and other stakeholders (different local professional groups) in a pressure group to perform a monitoring role, and in the role of raising awareness about user's rights and claims in order to influence people's behaviour in demanding good quality and acccountable health care.

The efficiency function included making local public health services more accessible to the users and in particular poor users who were otherwise excluded due to barriers, like a lack of peer support and networks, social clout and connections. Making public health services more responsive to local people's needs by making them directly answerable to users formed another important efficiency function of the CA.

4. Operation

The selection process of the group was conceived to be very democratic and participatory, with participation by representative from all socio-economic classes. It was believed that wide participation of stakeholders would be ensured by arranging a one-day workshop at the local level at which a large number of participants, including Ministry officials, NGO officials from the area and the headquarters, donor representatives and local residents,

service users and local professional groups, would be invited and asked to select the health watch group[24]. Proper representation of all segments of the population and stakeholders would be ensured by including all local professions and representatives from marginal groups like women and the landless, NGO representative and local elected representatives. The explicit criterion for inclusion was local residence, while the explicit exclusion criterion, specifically required by the guideline provided by the MOHFW for the formation of the health watch group, was government officials and health care providers posted at the relevant health facilities.

The actual selection process was by "popular voting" at the end of the workshop and was described to very participatory because it was "spontaneous". However, the selection of the members was strongly guided by the NGO facilitator[25]. Since the elite and more powerful sections of the population usually tend to dominate membership in local committees set up by government ministries, in reality this meant that representation of marginal and poorer sections of the population, with whom the NGO has an established relationship, was easily ensured. In fact, the selection of members was actually biased in their favour, with the elite of the locality and local influential people actually being excluded[26].

The exclusion of local influential persons may not have been strategic, and the consequence was an absence of ownership of the health watch group by local residents and a general lack of confidence about their ability to attain the objectives of monitoring performance of health care providers[27]. There were also costs of excluding health professionals working at the health facility, indicated by the fact that service providers, especially health professionals, viewed their monitoring role with considerable skepticism[28]. Although the thana health and family planning officer (THFPO) was invited to attend the initial workshop he was completely unaware of the activities of the health watch group since October 1999 and claimed that they had not seen any member of the group visiting the health complex. Hence, the general attitude of the health care professionals about the role of the health watch group was one of doubt with respect to their capability and disregard for their authority to monitor.

[24] The guidelines for conducting the participatory workshop and mechanism for selection of the stakeholder watch group were provided by the MOHFW. According to these guidelines the group was to include nine members of the local community served by the health facility, who were a school teacher, journalist, advocate, landless farmer, a poor woman service user, local traditional doctor, woman member of the union parishad, and the NGO worker who would act as the member secretary.

[25] The majority of the members were personally known to the NGO worker previously, although they were relatively unknown to the users who were interviewed. In one group one of the members is the president of the landless samity organised by the NGO in the village and he began his presentation at one of the meetings attended by our interviewer with a song that strongly reflected the NGO's own agenda.

[26] This is suggested by the fact that most of the members of the health watch group were not readily recognized, as local elite and influential persons usually are, by the users of the thana health complex interviewed by us They also commented that only people belonging to the samities organized by the NGO were selected. Moreover, a local leader of the ruling party, who was himself active in protesting about food served to patients at the thana health complex, was also not included.

[27] Local residents and users of health facilities interviewed by us expressed doubts about the effectiveness of a monitoring committee whose members were not local residents and lived far from the health facility. They also felt that the members were not qualified enough to question the activities of the doctors.

[28] The thana health and family planning officer actually mentioned that he did not feel that school teachers, journalists or women union parishad members had the requisite competence to monitor the performance of doctors by examining prescriptions or to decide whether doctors were negligent or not.

Relationships within the group were extremely hierarchical. Although authority to run the affairs of the committee was supposed to be equally divided among the committee members, there was a clear distinction of authority between the NGO facilitator, who was the member secretary, and the other members. While the regular monthly meetings of the committee were supposed to be convened and chaired by the president of the committee, the secretary actually conducted these monthly meetings[29]. The NGO worker as member secretary also had the responsibility to prepare the monthly reports to the donors and was the link with the powerful MOHFW. He also had higher educational qualifications than most of the individual members and would often have good working relationships with local government officers, often including the thana health officer whose performance the committee was supposed to monitor[30]. Lastly, the fact that none of the other members were confident enough to give individual interviews and were only accessible in the presence of the member secretary, suggested that members were in awe of the secretary. In fact, these factors indicated that the NGO worker was viewed as the defacto leader of the committee.

The leadership role was in fact ex-officio and went to the local NGO worker given the task of forming the health watch committee at the local level. Therefore, the selection process of this defacto leadership was prescribed rather than participatory because the decision about which NGO would be chosen to organize the stakeholder workshop and assist in the formation of the health watch committee was taken many months ago at meetings in Dhaka by the donors and MOHFW, and neither local people nor members of the committee had a say in that decision. The tacit acceptance of his leadership role does not necessarily mean that local residents and committee members were satisfied about his performance[31]. He was responsible for functional operation of the committee (arrange and conduct meetings, liaise with donors and Ministry officials from Dhaka, report to them directly, and hold committee members accountable for their activities). However, he was not involved in the substantive decisions regarding the composition, process of selection and role of the committee. Moreover, the NGO worker, despite his leadership role and the fact that he maintained direct working relationships with local government officials, was not able to bridge the existing social distance and communication gaps between committee members, who were local residents, and public health professionals posted in the area[32].

The decision making process within the committee was limited in the sense that activities of the committee were not very diversified, being largely awareness raising and motivational in

[29] In one monthly meeting attended by our interviewer the president began the meeting but immediately handed over the authority to conduct the business of the meeting to the secretary, while the other members merely reported their monthly activities and did not even comment or participate in discussion of reported activities.
[30] The NGO worker and secretary of the observed health watch committee was a close friend of the THFPO.
[31] Patients interviewed at the thana health complex were critical of the role of the NGO and the NGO worker who was secretary of the committee, claiming that they knew very little about the activities of the NGO and that the NGO had no links with local important and influential people because they only worked with the poor. There was no opportunity to get the opinion of committee members on this issue because the members were not readily available for interview and the NGO worker was always present when there was any discussion with them, for example at the monthly meeting of the committee.
[32] This is suggested by the fact that although the NGO worker and the THFPO were close friends, the latter had no idea who were the persons on the committee nor any notion of their activities.

nature. This is evident from the reports of the monthly meetings, which consisted only of accounts of activities of the past month by individual members and acceptance by the committee of the plan for the next month[33]. These reports, prepared by the NGO worker, did not mention any differences of opinion between members or requests for clarifications, and so on. Hence, it was not possible to ascertain the degree to which the decision-making process was participatory and democratic, although it appears that the process was dominated by the NGO worker who conducted the meetings[34]. However, it must be noted that the scope for participation in internal decision-making was limited by the fact that activities pursued by the committee were quite non-controversial in nature.

The formal mechanism for ensuring consistency of action of the committee members was through their attendance and public reporting of performance at the monthly meetings, which were attended by members of both union and thana committees[35]. The informal mechanism employed by the NGO worker was to get as many members as possible from among their own group members and from among local persons who were supporters of their programmes in the area, i.e., persons upon whom the NGO could rely. Given the fact that there were not many supporters and well-wishers of the committee among local residents and users of the thana health complex this mechanism apparently worked quite well since no internal conflicts were reported and at monthly meetings members appeared to be very well-disciplined and willing to follow instructions[36]. Consistent behaviour of the NGO was ensured by the control of funds by the donors, in this case represented by the World Bank, but the health watch committee itself had no mechanisms for monitoring the actions of the NGO worker to prevent activities that might undermine their role as a group[37].

The mechanism for internal accountability was quite elaborate. There was a three-tiered system of reporting, in which the answerability was from the health watch committee, to the NGO to the donor/MOHFW, and the mechanism for ensuring answerability was through the reporting of activities by the relevant NGO worker to the Ministry. This report was based on the reports presented by committee members at monthly meetings of the health watch committees, which were actually held quite regularly[38]. There has also been an independent evaluation conducted by the donor (the World Bank), the results of which are not yet

[33] Reported activities were found to be extremely similar in all the monthly reports examined as well as in one monthly meeting attended in March. These activities consisted of awareness raising and information dissemination about the HPSP, awareness raising about health problems among school students, assisting some poor women and men to avail health care at the local health facility and encouraging local residents to utilize public health services to a greater extent, assisting health providers of the satellite clinics to improve the performance of their duties, and holding the monthly meeting to review past and plan future activities.

[34] In one meeting attended by our interviewer future activities were suggested by the NGO worker and members readily accepted those.

[35] Members had to make oral presentations of activities and achievements in the past month.

[36] Most of the local residents and users of the thana health complex interviewed did not seem to have a very high opinion about the health watch committee and expressed skepticism about its activities.

[37] Although members had to make individual presentation of activities in the past month at the monthly meetings, the NGO worker did not have to report on his activities as a member of the health watch committee. It is also possible that his friendship with the THFPO may have undermined the capability of the committee to monitor the performance of the THFPO and other staff at the thana health complex.

[38] These meetings were supposed to be held every month for the union committes and every three months fro the thana committees.

available. However, the effectiveness of this system in ensuring that the committee and the NGO actually perform according to their TORs was not established since it was evident that the major activity of the committee, namely monitoring service provision at local public health facilities, has been the weakest and almost non-existent[39].

On the other hand, there was no system of accountability of the donors or the MOHFW to the health watch committee at the local level. As mentioned above, policy decisions regarding the role of the committee, its composition, and functions were made outside the committee, although these were disseminated at the local level through the workshop mentioned earlier. The lack of accountability of the Ministry was evident from the fact that even after two years the committees have not received official clearance from the Ministry giving them the authority to monitor and question the professional activities of local public health care personnel and service provisioning at local public health facilities[40]

The evidence suggests that the health watch committees were relatively less likely to be able to perform their claims functions fully. The major activity in this respect was monitoring the performance of professionals and staff at local public health facilities, but this was rarely undertaken. Even when performance monitoring was actually attempted this was restricted to monitoring the cleanliness of facilities, rather than the professional and service performance of doctors and staff, which were major factors responsible for the low use and accessibility of public health services by local residents[41]. Even when cleanliness was monitored and reported upon this was only for the satellite clinics, which are held twice a month in donated spaces outside the local public health facility, so that mainstream facilities like the thana and union health centres do not come under inspection. Hence, there was no presence or visibility of the committee in these health facilities, which was why almost all of the users were unaware of their existence as a health watch group.

The factors contributing to this lack of performance were both internal and external. First, the committees had not received the official authorization of the MOHFW to carry out monitoring activities. Second, the health professionals were doubtful about the ability of the committee to carry out monitoring effectively as they did not think the members were qualified to do it. Within the committee itself the members themselves may have felt that they were not competent, having received only a day's orientation from the relevant NGO, and probably felt it was not politically correct either to question the actions of government officers who were placed higher socially.

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[39] An examination of monthly reports sent by the local NGO worker, member secretary to the committee, from four thanas revealed that visits to the health centers by members of the committee were rarely reported, and even when reported there was only mention about the poor sanitation and cleanliness of the facilities, with no mention of the presence, behaviour and sense of responsibility of doctors and other staff.

[40] The MOHFW was supposed to issue authorization letters to individual members of the committee in October 1999. After waiting for these authorizations to arrive, the health watch committees in some areas began to function without those.

[41] A review of the monthly reports of activities of all the health watch committees formed by one NGO revealed that, except for a few mentions about the unclean premises of the satellite clinics, which meet twice a month to deliver immunisation and antenatal care, there was no report of activities of actual monitoring of the presence of doctors and other staff, their professional behaviour, access to available free drugs and medicines, and so on.

The performance of the committees with regard to the efficiency claims was more visible, as evident from the regular report of activities such as awareness raising about health problems and assisting people to avail services. However, the impact of their activities in raising local awareness of people's rights to accountable health service and in motivating local people to demand accountable service remains to be seen. Many of the users interviewed said that they did not have complaints about the service or the behaviour of the doctors and staff, even defending some of their actions[42]. They did not expect the local health center to be able to do anything about "serious" illnesses, despite the fact that the thana health complex was even equipped with an operating theatre.

5. Equity aspects

The actual costs of participation experienced by committee could not be directly ascertained since it was very difficult to interview them, but are unlikely to be very high. The fact that many of them lived at some distance from the local health facility suggests that there would have been some cost involved in terms of time and effort if the monitoring activity had been regular. In reality members were engaged almost entirely in village based activities that were not too time consuming. The cost of monitoring performance was perceived to be quite high since it prevented the committee members to refrain from actual monitoring. It is likely that this cost would have weighed more heavily on members than on the NGO worker who was not a local person but only posted on duty.

The benefits of participation do not appear to be significant either. Most of the members did not even gain in terms of added social status and local prestige, since they were not easily recognized by residents and users. The benefits to general users also do not appear to be great since very little change in service provision and performance of doctors and staff was noticed. Most of the users interviewed said that service was as before, which was neither good nor bad and as good as could be expected by poor people. In fact there was no visible presence of the committee at the health centers they were supposed to monitor. However, the other gains from the collective action of the committee were increased awareness about health problems and some increase in the access of poor women and men to service at the health center. To that extent the limited gains have been more beneficial for the poor.

[42] Some patients interviewed said what could doctors do if they were not supplied with medicine and drugs.

Case Study 4: Community Groups

1. Group identification

Within the context the Health and Population Sector Programme (HPSP) the Ministry of Health and Family Welfare (MOHFW) of the government seeks to deliver good quality health care to the population by promoting the direct participation of local residents and service users in service provision so that service providers are answerable to the local population. One of the strategies used to achieve this is the establishment of the health watch committees (presented in the previous case study) to monitor the performance of health care providers in existing public health facilities like the thana and union health centers. Another approach is to provide accessible essential health care to the rural population through newly established and community owned and managed clinics at the grassroots level. Through this approach government wishes to increase the accessibility to essential health care of the most vulnerable and deprived sections of the rural population (women, children and the very poor) by making a package of essential health services available within the community. It is believed that ownership by the community and easy accessibility by the people will increase the responsiveness of providers to the needs of the most vulnerable groups. This will also make providers more answerable to the people who use it since ownership means that the community will have the authority and mandate to demand accountable and good quality service. It is further believed that accountability to the state of public agencies and employees delivering health care will also increase if they are made answerable to the people they serve.

To this end, and after several experiments, the government decided to set up community clinics in every village/ward to provide essential health services to the community from an easily accessible one-stop centre. Clinics would be located on donated land within the village and the costs of construction and operation of the clinic would be shared by the government and the community[43]. The delivery of the essential services package (ESP) through the clinic would also be jointly managed by the government, represented by local elected representatives at the union level, and the community, represented by a community group selected by the community. Hence, this was a collective action based on the partnership of the MOHFW, the union parishad (local government) and the local community.

The interest of the MOHFW in this CA was to ensure that the ESP was easily accessible to the most vulnerable groups in the rural population and that service providers were responsive to their immediate health needs. The interest of the union parishad was to have an active role in the implementation of government programmes at the union level as this would enhance their credibility for governance. The interest of the local community was to have an answerable essential health service in the locality that maintained a minimum standard of quality and was easily accessible to members of the community.

[43] The government provides a one-time grant for construction of the clinic and required personnel, equipment and supplies and furniture. The community provides the land, supervision of construction, routine cleanliness and maintenance of the clinic, security and management of service provision.

2. Reason for mobilization

The major reason for mobilization was to establish the community's right to demand and to receive essential public health care that was of good quality and responsive to their immediate needs. Although the right to essential health care was a formal commitment of the state there has been a failure of provision, not only because of the absence of provision, i.e. inadequate availability of public facilities, but also because of resource and recognition constraints that prevented access by the most vulnerable population groups to existing public facilities. The second reason was to influence the action of others in order to redress the failure of provision of this right, i.e., the action of service providers as health care professionals, and the actions of the community as citizens who were responsible for demanding their right to essential health care.

3. Functions

This collective action of the Ministry, the union parishad and the local community, thus, had both claims and efficiency functions. The claims function was to establish people's right to demand and have access to public services that provided good quality and accountable essential health care. The efficiency function was to actually ensure people's access to these services, especially the access of the most vulnerable groups, and make services more effective by establishing ownership of service provision by the community.

4. Operation

The above functions would be operationalised by establishing community ownership of a grassroots clinic that would provide the ESP to a population of 6,000 persons. Community ownership would be established through a "community group" (CG) entrusted with the mandate to construct, manage, implement and maintain the community clinic The union parishad, after discussions with thana level health and family planning officers and field workers and members of the local community would form the CG, which would consist of elected union parishad members, government health workers and representatives of the community who were committed to social work and represented various occupation groups and social classes. In reality, the main initiative for establishing the community clinic in this case came from a strongly motivated and influential doctor who was a local man but not a resident, and the CG was selected at a meeting of local influential and elite persons, thana and union level government health workers and local elected representatives[44]. The CG consisted of seven members, two of whom were elected union parishad members, one man and one woman; two members of the community residing in the two villages covered by the clinic, a teacher and a village doctor; the land owner who was the ex-officio president of the

[44] The meeting was actually convened by an influential local person, a doctor by profession, who had previously been interested in setting up a charitable clinic on his own land to serve his neighbours who were deprived of health care because of poverty. The land for the clinic was donated by the younger brother of this man, who, however, was not very interested in this initiative. The doctor complained that his brother, being the land owner was the ex-officio president of the community group but was hardly involved in its activities and did not even live in the village. He was also not available for interview.

group; the health assistant posted at the clinic who was the ex-officio secretary to the group; and the family welfare visitor posted at the clinic, a woman.

The formation of the CG was, thus, quite selective and did not emerge from a broad-based consensus of the community. In fact, the three members representing the village community were all relatively well-off village elite having close personal relationships with the person who was the primary initiator. Thus, there was an implicit criterion for inclusion into the CG based on social status and personal relationships, and representation of the community in the CG was biased towards professional occupations and relatively higher social classes. This was balanced, however, by the inclusion of elected local government representatives, including a woman, and the inclusion of locally posted health service providers. The inclusion of these members helped to increase the acceptability of the CG within government machinery[45], but acceptability within the community, which could only be inferred but could not be verified, may have been limited[46].

However, the lack of official and legal recognition from the MOHFW was responsible for an inherent lack of authority and credibility that constrained the functioning of the community group[47]. For example, fund mobilization for clinic maintenance was one of the mandates of the group that was rendered difficult by the lack of a legal basis[48]. Higher government officials at the thana and union levels, such as the thana executive officer (TNO) and the union executive officer (UNO), did not always recognize the mandate or decision-making authority of the CG with regard to management of the community clinic and would even override decisions taken by the CG[49]. The CG also failed to establish its authority to monitor and supervise the quality of construction of the clinic by building contractors hired by the local government engineering department.

Relationships between the members of the CG did not appear to be hierarchical, but seemed to be one of mutual reciprocity and reliance[50]. This is also suggested by the fact that, unlike the case of the health watch committee, the members of the CG representing the community

[45] For example, the THFPO provided medicines and some other supplies from the thana Health Complex although he was not obliged to do so.

[46] The doctor who liased with the MOHFW and was active in establishing the clinic was critical of the CG on the grounds that they had not been able to generate sufficient local interest in the affairs of the clinic. The CG had also not been able to establish enough moral authority in the community to allow them to mobilise funds from the community for clinic maintenance.

[47] The absence of legal basis for authority of the community group was noted at the dissemination workshop on training of community groups held in Dhaka on March 28, 2001, and a suggestion was made that there should be a "social contract" signed between the community groups and the MOHFW through the THFPO to give them a legal basis for action.

[48] One CG member, the school teacher, reported that they did not feel comfortable about charging user fees from patients at the clinic because of the fear of being accused of collecting donations or making money for themselves.

[49] In one instance the UNO ordered the community group to stop charging a fee of Tk.10 per family per month that was collected from users to raise funds for maintenance of the clinic.

[50] The health assistant of the clinic, who is also the secretary of the CG, often sought the advice of the village doctor when there was a complicated collective actionse he could not handle on his own. Members of the CG also shared the costs of entertaining visitors. The school teacher and the village doctor both appeared to have cordial relations with the health assistant.

provided information in a very open and frank manner without being in awe of the president or the secretary of the CG[51].

On the contrary, there may actually be a problem of a lack of leadership and the proper delineation of authority and responsibility within the CG. The president of the CG was an ex-officio position and his participation in the activities of the CG was hardly ever mentioned, even in relation to several crucial decisions taken by the CG like the withdrawal of user fees in the face of objections by the union level executive officer, the inclusion of more solvent residents into CG membership in order to make fund mobilisation easier, and so on. He was also physically absent for a long period because of religious commitments[52]. Thus, the leadership role of the president was not at all evident. Weak leadership was also indicated by the fact that only three meetings of the CG were held in the last one-year in place of one meeting per month; the CG was ineffective in fund mobilization from the community; and was unable to establish its mandate with regard to the thana and union health authorities who had the responsibility of supervising service provision at the clinic. The default leadership role in establishing the clinic and selecting the CG was readily assigned to the brother of the president, who had actually liaised with the MOHFW to bring the clinic and had persuaded his younger brother, a resident of the community, to donate their land for the clinic. He was not eligible to be a CG member because he was not a community resident[53].

The functional achievement of the collective action has to be assessed in view of the nature of its operational performance. The CG had been in operation for about a year, during which time it was given the responsibility of arranging land for the clinic, supervising construction of the clinic building, administering the provision of the ESP, monitoring the performance of the service providers, maintaining the security and cleanliness of the clinic, and generally establishing a sense of ownership within the community. The performance with regard to initially setting up the clinic was good but subsequent administration of service provision was not satisfactory[54]. Its achievement with respect to establishing community ownership of the clinic was limited, as evident from the fact that, apart from the CG members, there was not yet a lot of interest about the clinic and the activities of the CG within the community[55].

[51] All three members of the CG representing the community were available for interview and talked quite freely. Their reports of activities and meetings of the CG did not mention either the secretary or the president of the CG taking a leading or dominant role, and decisions appeared to be quite democratic as suggested by the report of the school teacher member on the decision to expand membership to include persons who were solvent and able to contribute funds for clinic maintenance.

[52] The meeting of the CG was not held for quite a while because the president was away on a "tablig" mission.

[53] The fact that he was not a member of the CG and not allowed to have a say in the management of the clinic weighed heavily upon him, and he complained openly about the inefficiency of the CG in managing and running the clinic.

[54] The clinic was found closed by us on the first visit although patients were waiting. The doctor responsible for initial liaising with the MOHFW to bring the clinic complained that the clinic was often closed without notice, causing a lot of inconvenience to patients who came from far. He also said that the CG was ineffective in generating community interest in the affairs of the clinic and that the members and the president, his own brother, were not very serious about their management role.

[55] An indication of this is that the CG did not feel that they had the moral authority to raise funds from the community for clinic maintenance and were thinking of expanding membership to directly involve more influential people in the community in management.

However, the members were aware of its limitations in this regard and the CG was considering ways to raise community interest and participation.

In summary, the actual performance of the CG suggests that it has not yet become fully operational, and a number of factors may be responsible for the sub-optimal performance. The absence of leadership within the CG is likely to have undermined its strength and the effectiveness of its mandated role. The lack of a legal basis and official recognition is also responsible for the poor credibility of the CG within the health system and other government machinery at the local level, as well as low moral authority within the community. In addition, low level of community awareness about rights regarding the provision of health care has meant that service providers do not feel accountable or answerable to the users even within a small community where personal relationships matter, and hence service quality suffers.

5. Equity aspects

The costs of membership in the CG were not large, mainly because the CG had not yet become totally functional. At the present level of activity the main costs were those of time, and some costs related to fund mobilisation. The time costs were quite negligible since meetings were infrequently held and members' activities with respect to generating community interest and a sense of community ownership were quite minimal. However, there may be some cost related to fund raising, in terms of community mobilisation, when the CG becomes involved in this activity. At present, the costs were borne primarily by two or three members, who lived near the clinic. The president bore the cost of the land, but seems to have very little other cost.

The benefits of CG membership were not very apparent. Since the acceptability of the CG in the community was not yet established benefits in terms of improved social status was not likely to be high. There could be some benefits in terms of greater interaction with local government officials. Benefits, if any, were mostly related to the sense of satisfaction that came with a commitment to social work. Both the school teacher and the village doctor mentioned their desire to participate in making health care more accessible to the poor in their community.

Concluding observations

The four case studies of collective actions have been quite diverse and the attempt to put them into a common analytical framework has been a struggle but a useful one. The analysis provides only first responses to the research questions posed in the beginning. One needs to be wary of drawing conclusions from what is, after all, a very small and selective sample of collective actions.

What were the emerging meanings of citizenship that these collective actions implied?

There were no explicit attempts to arrive at a definition of citizenship that spelled out people's formal rights and/or perceived claims and the obligations of the state, the community and the market to its citizens or its constituency. However, notions of citizenship were implied in the way the "citizen's group" involved in the struggle was defined. For example, in the first case this group consisted of students only, excluding school authorities or guardians who could have been part of the group as they also had legitimate rights or claims that were included in the collective action. In the case of the health watch committee, although the attempt was to arrive at an inclusive concept of citizenship comprising of all relevant sub-groups, in reality the "citizen's group" emerged as a class-based group that excluded the relatively non-poor, especially those who did not belong to samities organised by the NGO. For the family planning association the implied concept of citizenship was also class-based, but this time consisting of the rural and urban elite (better-off, educated, youth). In all the collective actions studied a concept of the legitimate citizen was emerging, but these were initially fragmented and usually very selective. Thus, contemporary collective actions were not able to foster either explicitly or implicitly a common and generally relevant meaning of the citizen with which different types of citizen's groups and individuals would be able to readily identify and around which they would be able to mobilise.

To what extent were rights recognised and articulated?

The articulation or recognition of rights was much more explicit and identified with greater clarity and relevance, especially those rights that had a direct relevance to people's everyday lives, i.e., the rights of students to text books, the rights of users to quality health service, the right of women to have a say in reproductive decision making, and people's right to participate in community health care provision. However, rights at a higher level or rights that were somewhat removed from people's immediate daily realities, such as the right to have accountable state and market agents, was not identified as clearly although this was a major objective in three of the collective actions. The right to demand accountability of agents and institutions that were considered more powerful than those involved in the collective action was not only less understood, but was sometimes even denied or negated. For example, both school authorities and the organising students believed that school management did not have the authority of questioning the NCTB's actions as they were recipients of government grants. Again, both health service providers and users thought that the health watch committee did not have the mandate nor was competent enough to monitor the performance of the health care professionals and staff in the thana health complex.

Consequently, the mechanism of using people's participation as a tool to ensure accountability was also not well perceived. Demanding responsibility for actions and the answerability of state, market or community agencies and institutions from outside and below, i.e., through the process of people's participation, termed vertical accountability (Bellour and Newell 2000), was not seen as legitimate behaviour on the part of citizens or indeed considered to be an integral part of being a "citizen". This is evident from the textbook collective action, the health watch committee and the community group. Thus, although the collective actions may have buttressed the weak or non-existent internal accountability (being answerable to equals or to those within the system, although there is no evidence) through people's participation in monitoring and overseeing, the outcome was not very effective in terms of external accountability, i.e., being answerable to those outside the system who may even be less powerful. Hence, the people's right to accountable performance by state, market and community agencies and institutions could not be established or even well articulated by the collective actions, except in the case of family planning association. One likely reason for such failure would be the considerable imagined cost perceived by those engaged in the collective action, especially in those collective actions involving confrontation with established structures that impeded the provision of rights.

Were these collective actions able to overcome resource constraints in the provision and enjoyment of rights?

Poverty, a lack of education and the absence of organisation all constrain people's access to both public and privately provided services. Hence these constitute major resource impediments to the identification, provision and enjoyment of basic rights. These constraints also prevail in the internal operation of the group engaged in a collective action. For example, in the oversight community group wealthy and influential persons involved with the establishment of the community clinic carried a lot of weight with the service providers of the essential services package at the community clinic although they were not even local residents. This was reinforced by the fact that the clinics were usually built upon land donated by a wealthy member of the community group. The health watch committees, which were consciously constituted to have a wide representation especially of the poor, also failed to establish their role of monitoring the performance and demanding answerability of health professionals and staff at public health facilities. Thus, collective actions may not be very effective in overcoming resource constraints imposed by poverty and education despite being inclusive enough to represent all classes and sections of the population.

However, some collective actions were able to overcome the resource constraint of organisation and were effectively able to provide the support of the group to the less organised sections of the population who had little clout. In the textbook case the fact of being organised in a collective action lent a lot of credibility and weight to the demand of the school students, a relatively powerless section of the population. In the family planning association case also the strong organisational support was essential in initially addressing

and later establishing the rights of a section of the population whose rights were among the least recognised and most denied by society and all its institutions.

Were these collective actions able to overcome recognition constraints in the provision and enjoyment of rights?

Collective actions were relatively more effective in the identification and articulation of rights that faced recognition constraints. This was in large part because of their capacity to organise groups with shared interests around a common violation of rights, and is evident from all four case studies. This appears to be the greatest strength of the Collective actions. In some collective actions, however, the mobilization, despite being well conceived, turned out to be weak because of being too hierarchal, such as the health watch committees and the community group. In these instances the weak mobilisation and organisation may have been responsible for the fact that the demand for the provision of accountable public service was not strongly perceived by the group and even denied by the service providers. The other difficulty in overcoming recognition constraints was the inability of the collective actions to come up with an inclusive concept of citizenship that would allow or make it legitimate for all citizen's groups to mobilise around a specific right, whether it was school students' right to textbooks, or women's right to have a say in fertility decision making, or user's right to accountable health service. In other words, the effectiveness of a collective action in overcoming recognition constraints could be greatly enhanced with the evolution of a definition of the citizen (an individual with rights and obligations) and a concept of citizenship (the relationship between the citizen and the state, community and the market) that was more integrated and less selective.

What do the diverse interests of the partners tell us about the emerging concept of citizenship?

The cases studied suggest that collective actions that were initiated by groups who had no self interest to pursue other than the articulation and establishment of rights and claims generally and had no potential direct gains in terms of their own rights and claims were more effective in operational performance and in the achievement of their objectives. In the textbook case the student organization did not have any direct self-interest in terms of own claims to subsidized textbooks. They were self motivated to engage in the collective action, which was to establish the rights of school students who were, in fact, a group that was most vulnerable to violation of rights, having relatively less power and clout compared to other student groups or even other interest groups, like school managers and guardians. In the family planning association case the initiation of the action was by a group of highly motivated and socially successful professionals who were interested to reduce women's oppression and powerlessness with regard to child bearing and establish the right of women, particularly poor women, to have a say in reproductive decision making, but did not have any direct self interest in the action. The social and political clout of the group was very strong and the collective action was for establishing the rights of one of the least powerful groups in the society, namely poor women.

In both collective actions the struggle to establish rights was undertaken by a self-motivated but disinterested group for a relatively less powerful but interested group in society who would otherwise not have had the resources or the recognition to mobilize a collective action on their own. In these two collective actions, therefore, the implicit concept of citizenship would appear to be relatively less selective and exclusionary since the non-provision or violation of the rights of a powerless group are pursued, struggled and lobbied for by another more powerful group whose rights may not have been violated at all or to the same extent. In other words, the partnerships forged by the collective action and the citizen's struggle indicates that a more inclusive concept of citizenship has been operational and even sustained to some extent under certain situations.

How equitable were the costs and benefits experienced by the different partners in the collective action?

The case studies revealed that participation in a collective action imposed burdens on the different partners, but usually more in terms of anticipated rather than actual costs. In some cases the perception of anticipated costs was high enough to deter participation, which happened with school management of different schools in the textbook collective action. In other cases perceived costs did not prevent participation but caused participation in the collective action to be less than optimal and the objective or function of the collective action to be pursued in only a limited manner. This was the situation in the health watch committee, where members of the committee did not feel competent or were not inclined to perform their role of monitoring the performance of health professionals and staff probably from fear of offending them.

The real costs of participation in collective actions were relatively small, and consisted largely of time and effort costs when participation was voluntary, such as for the students in the textbook case and for the volunteer members in the family planning association. The magnitude of real costs varied according to the degree of participation, but the voluntary nature of participation indicated that these costs were unlikely to be inequitable.

The nature and magnitude of benefits were quite varied depending upon the reason for participation. When participation did not involve self-interest and was voluntary benefits were usually and apparently small, comprising of the enhancement of self-esteem and satisfaction, social prestige, and so on. When participation was for serving direct interests, like protesting the non-provision or the violation of a right, potential benefits could be relatively larger. Hence, without being inequitable benefits were not experienced by all partners to the same extent, being contingent upon the specific interest of the partner in joining the collective action. In most cases benefits were potentially large when costs, either perceived or actual, were large, for example for school students in the textbook case the benefit of timely access to subsidised and good quality textbooks would be quite significant, while the cost of being caught by school authorities or guardians would also have been severe. Similarly, the potential benefits to partners and the larger community of an accountable and quality public health service would be quite large, while the perceived costs of actually monitoring the performance of health professionals would also be large.

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